

AMENDED IN SENATE MAY 21, 1997

AMENDED IN SENATE APRIL 14, 1997

**SENATE BILL**

**No. 1194**

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**Introduced by Senator Rosenthal**

February 28, 1997

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An act to amend Section 14087.325 of, and to add Section 14087.326 to, the Welfare and Institutions Code, relating to public social services.

LEGISLATIVE COUNSEL'S DIGEST

SB 1194, as amended, Rosenthal. Medi-Cal: contracts for services and case management.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law provides that the department shall require, as a condition of obtaining a contract with the department, that any local initiative, as defined, shall offer a subcontract to all federally qualified health centers in its service area.

Existing law specifies the procedure for determining the reimbursement of federally qualified health centers contracting with local initiative or ~~—mainstream~~ *commercial* plans within their respective service regions, and requires the department to perform reconciliations to determine a federally qualified health center's reasonable cost.

This bill would require that any ~~mainstream~~ commercial plan shall be required to offer a subcontract to all federally qualified health centers within its services region.

This bill would also require the department to report the mechanism for calculating the percentage of capitation rate dedicated for the purpose of contracting with federally qualified health centers to the ~~mainstream~~ commercial plans, the local initiatives, and the federally qualified health centers.

Existing law requires the department to provide incentives in the competitive application process to encourage potential ~~mainstream~~ commercial plans to offer subcontracts to federally qualified health centers.

This bill would eliminate that requirement.

This bill would require local initiatives or ~~mainstream~~ commercial plans to assign Medi-Cal beneficiaries who do not choose a primary care provider, and have no existing provider-patient relationship, to safety net providers ~~and traditional clinics~~, *subject to certain ratio and capacity limitations*.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 14087.325 of the Welfare and  
2 Institutions Code is amended to read:  
3 14087.325. (a) The department shall require, as a  
4 condition of obtaining a contract with the department,  
5 that any local initiative, as defined in subdivision ~~(g)~~ (v)  
6 of Section 53810 of Title 22 of the California Code of  
7 Regulations, and any ~~mainstream~~ commercial plan, as  
8 defined in subdivision ~~(h)~~ (g) of Section 53810 of Title 22  
9 of the California Code of Regulations, offer a subcontract  
10 to any entity defined in Section 1396d((l)) (1) (2) (B) of  
11 Title 42 of the United States Code providing services as  
12 defined in Section 1396d(a)(2)(C) of Title 42 of the  
13 United States Code and operating in the service area  
14 covered by the local initiative's or ~~mainstream's~~  
15 *commercial plan's* contract with the department. These

1 entities are also known as federally qualified health  
2 centers.

3 (b) Except as otherwise provided in this section, the  
4 subcontracts offered pursuant to subdivision (a) by a local  
5 initiative or ~~mainstream~~ *commercial* plan shall be on the  
6 same terms and conditions offered to other  
7 subcontractors providing a similar scope of service.

8 (c) Pursuant to Section 1396b(m)(A)(ix) of Title 42 of  
9 the United States Code, reimbursement for services  
10 provided pursuant to a subcontract with a local initiative  
11 or a ~~mainstream~~ *commercial* plan shall, at the election of  
12 the center, either be on the basis of the federally qualified  
13 health center's reasonable cost or be based on terms  
14 negotiated between the center and the individual local  
15 initiative or ~~mainstream~~ *commercial* plan. If the center  
16 elects to be reimbursed on the basis of its reasonable cost  
17 as a term of the subcontract, the subcontract between the  
18 center and a local initiative or the center and a  
19 ~~mainstream~~ *commercial* plan shall provide that the  
20 center shall be reimbursed at the interim per visit rate  
21 established for the center by the department or at a  
22 capitated or fee-for-service rate that is the equivalent of  
23 the interim rate. The subcontracts entered into pursuant  
24 to these requirements shall be for the provision of all  
25 ambulatory services provided by the federally qualified  
26 health center and covered by the local initiative or  
27 ~~mainstream~~ *commercial* plan's contract with the  
28 department. Each subcontract shall provide that the  
29 center keep a record of the number of visits by plan  
30 members separate from visits of Medi-Cal beneficiaries  
31 who are not members of that plan.

32 (d) On an annual basis, but within six months from the  
33 end of the federally qualified health care center's fiscal  
34 year, the department shall perform a *an interim*  
35 reconciliation to determine the federally qualified health  
36 center's reasonable cost and shall pay to or recover from  
37 the center the difference between the reimbursement  
38 paid to the center by a local initiative or a ~~mainstream~~  
39 *commercial* plan pursuant to a subcontract with the

1 center and the center's reasonable cost for all visits to the  
2 center by plan members.

3 (e) A federally qualified health center may voluntarily  
4 agree to enter into a risk-sharing arrangement and shall  
5 not be required to seek reconciliation with the  
6 department.

7 (f) The department shall approve all contracts  
8 between federally qualified health centers electing  
9 reimbursement on the basis of cost and any local initiative  
10 or ~~mainstream commercial~~ plan to ensure compliance  
11 with federal law.

12 (g) (1) In calculating the capitation rates to be paid to  
13 local initiatives and the ~~mainstream commercial~~ plans,  
14 the department shall include the dollar amount of the  
15 interim rate payments made to these entities in the  
16 Medi-Cal fee-for-service program.

17 ~~(2) Effective July 1, 1996, and annually thereafter, the~~  
18 ~~department shall update the capitation rates for the local~~  
19 ~~initiatives and mainstream plans to include the dollar~~  
20 ~~amount of the interim rate payments that reflect the most~~  
21 ~~recent federally qualified health center cost and~~  
22 ~~utilization data.~~

23 ~~(3)~~

24 (2) The department shall report the percentage of the  
25 capitation rate paid to both the local initiative and  
26 ~~mainstream commercial~~ plans that is dedicated for the  
27 purposes of contracting with federally qualified health  
28 centers. The report shall be made to the local initiative  
29 plans, the ~~mainstream commercial~~ plans, and federally  
30 qualified health centers, and shall contain a description of  
31 the actuarial analysis used to make the capitation rate  
32 determinations.

33 (h) Effective July 1, 1996, the department shall update  
34 the rates for local initiatives to reflect more recent  
35 federally qualified health center costs and utilization  
36 data. Each local initiative contract shall limit risk  
37 associated with subcontracting with federally qualified  
38 health centers. The contract shall require the department  
39 to reimburse each local initiative's aggregate total  
40 payments to subcontracting federally qualified health

1 centers in excess of 110 percent of the dollar value of  
2 interim rate payments for these centers paid by the  
3 department in the capitation rates paid to the local  
4 initiative. Each local initiative shall reimburse the  
5 department for the aggregate total payments to  
6 subcontracting federally qualified health centers below  
7 90 percent of the dollar value of interim rate payments for  
8 these centers made by the department in the capitation  
9 rates paid to the local initiative. For each local initiative  
10 that begins operation after January 1, 1995, provided the  
11 plan submits required expenditure data to the  
12 department in the form, manner, and timeframe  
13 specified by the department, the department shall,  
14 during every six months of plan operation, perform an  
15 interim reconciliation to determine the variance  
16 between the funds that have been paid to the local  
17 initiative in its capitation rates to reflect the dollar value  
18 of federally qualified health center interim rate payments  
19 made to these entities in the Medi-Cal fee-for-service  
20 program and the amount that the plan has paid to  
21 subcontracting federally qualified health centers. If,  
22 pursuant to subcontracts with federally qualified health  
23 centers that have been reviewed and approved by the  
24 department, the local initiative has paid subcontracting  
25 federally qualified health centers in the aggregate an  
26 amount greater than 110 percent of the amounts included  
27 in the local initiative's capitation rates for this purpose,  
28 the department shall pay the local initiative the amount  
29 in excess of 110 percent. If the local initiative has paid  
30 subcontracting federally qualified health centers in the  
31 aggregate an amount less than 90 percent of the dollar  
32 value of federally qualified health center interim rate  
33 payments included in the local initiative's capitation  
34 rates, the local initiative shall refund the amount below  
35 90 percent to the department.

36 (i) After the end of the contract rate period of October  
37 1, 1999, to September 30, 2000, inclusive, the department  
38 shall conduct a final reconciliation, to the extent  
39 practicable within six months, in the manner specified in  
40 subdivision (h). This reconciliation shall cover the period

1 between the initiation of local initiative operations and  
2 the end of the contract rate period, and shall be made in  
3 accordance with the findings of the department's  
4 financial and administrative audit of plan operations. The  
5 reconciliation between the department and the local  
6 initiatives as described in this section shall not be made  
7 in contract periods beginning on or after October 1, 1997  
8 2000.

9 (j) Nothing in this section shall preclude the  
10 department from carrying out a pilot project in one or  
11 more of the designated managed care counties to study  
12 different reimbursement and reconciliation mechanisms  
13 to ensure reasonable cost reimbursement and adequate  
14 cash-flow to the federally qualified health centers.

15 (k) Nothing contained in this section shall be  
16 construed to invalidate any contract that was executed  
17 between a federally qualified health center and any local  
18 initiative or ~~mainstream~~ commercial plan prior to  
19 January 1, 1998.

20 SEC. 2. Section 14087.326 is added to the Welfare and  
21 Institutions Code, to read:

22 14087.326. (a) For the purposes of this article, "safety  
23 net clinic" means any *public or* private, nonprofit,  
24 community clinic or health center, including a federally  
25 qualified health center, that provides comprehensive  
26 primary care services to a significant total number of  
27 Medi-Cal and medically indigent patients in relation to  
28 the total number of patients served by the clinic.

29 (b) Each ~~mainstream~~ commercial plan and local  
30 initiative shall ensure that Medi-Cal beneficiaries  
31 maintain existing patient-provider relationships, to the  
32 maximum extent possible.

33 ~~(c) Each mainstream plan and local initiative shall~~  
34 ~~assign Medi-Cal beneficiaries who do not choose a~~  
35 ~~primary care provider, and do not have an existing~~  
36 ~~provider-patient relationship, to safety net clinics and~~  
37 ~~traditional providers within their provider network who~~  
38 ~~meet geographic standards and linguistic requirements.~~

39 ~~(d) Mainstream plans and local initiatives shall not cap~~  
40 ~~assignments to safety net providers below that which is~~

1 ~~required by the patient-provider ratios and capacity~~  
2 ~~limits established in the Knox-Keene Health Care Service~~  
3 ~~Plan Act of 1975 (Chapter 2.2 (commencing with Section~~  
4 ~~1340) of Division 2 of the Health and Safety Code).~~

5 *(c) If Medi-Cal beneficiaries choose or are assigned to*  
6 *a local initiative or commercial plan, but fail to select a*  
7 *primary care provider or clinic, at a minimum, the local*  
8 *initiative or commercial plan shall assign beneficiaries to*  
9 *safety net clinics using the same process for assignment*  
10 *that is extended to other primary care providers in the*  
11 *local initiative or commercial plan network, up to the*  
12 *patient-provider ratio and capacity limits set out in the*  
13 *Knox-Keene Health Care Services Plan Act of 1975,*  
14 *Chapter 2.2 (commencing with Section 1340) of Division*  
15 *2 of the Health and Safety Code. Nothing in this section*  
16 *shall preclude a local initiative or commercial health plan*  
17 *from assigning Medi-Cal beneficiaries on a preferential*  
18 *basis to safety net clinics in the provider network who*  
19 *meet geographic standards and linguistic requirements.*

